



STATE OF TENNESSEE

DEPARTMENT OF FINANCE AND ADMINISTRATION

BUREAU OF TENNCARE

REQUEST FOR INFORMATION

FOR

MANAGED CARE ORGANIZATION SERVING

MIDDLE TENNESSEE REGION

RFI NUMBER: 318.65-217

TennCare Request for Information Middle Tennessee Region

I. Introduction

Over ten years ago, on January 1, 1994, Tennessee began a new health care reform program called TennCare. TennCare essentially replaced the existing Medicaid program in Tennessee and expanded coverage to certain uninsured and uninsurable persons who were not eligible for the traditional Medicaid program. TennCare provides all physical and behavioral health services through managed care companies. TennCare enrollees in need of long-term care services (nursing facility and home and community based waiver services) receive those on a fee-for-service basis. TennCare is authorized by the Federal government (the Centers for Medicare & Medicaid Services) as a research and demonstration project pursuant to section 1115 of the Social Security Act.

II. Statement of Purpose

The purpose of this Request for Information (RFI) is to determine whether there are qualified managed care organizations (MCOs) that are interested in successfully serving the Middle Tennessee Region under the reformed model (described in Section IV below). In addition, Tennessee would like suggestions/recommendations from interested MCOs regarding specific aspects of the reformed model. The goal of the reform is to contract with MCOs that have extensive experience serving the Medicaid market and will be active partners with the State in providing quality services to enrollees while managing costs.

III. TennCare: A Snapshot

A. History of TennCare

As noted in Section I above, the TennCare program began January 1, 1994 to replace the existing Medicaid program in Tennessee. It was implemented as a five-year demonstration project approved by the Federal government pursuant to section 1115 of the Social Security Act. Tennessee received several extensions

after the initial expiration date of December 30, 1999. In July 2002 Tennessee received approval for another five-year period.

In a 2002 proposal to the Federal government the TennCare population was divided into two major eligibility groups: TennCare Medicaid, which is for persons who are eligible for Medicaid under the State Plan, and TennCare Standard, which is for persons who are not Medicaid eligible but who have been determined to meet the State's criteria as being either "uninsured" or "uninsurable". One purpose of having TennCare Medicaid and TennCare Standard was to offer a different benefit package to each group. However, the benefits for each group remained almost identical. Although the benefits were not different, TennCare Standard enrollees with family incomes at or above poverty were required to pay premiums and copayments. TennCare Medicaid enrollees were not required to pay premiums or copayments. Since that time there have been additional changes to eligibility, benefits, and cost sharing. See below for current information.

TennCare health care services are offered through several managed care entities. Each enrollee has a managed care organization (MCO) for his/her physical health services, a behavioral health organization (BHO) for his/her mental health and substance abuse treatment services, and a pharmacy benefits manager (PBM) for his/her pharmacy services. Children under the age of 21 are eligible for dental services, which are provided by a dental benefits manager (DBM). Enrollees are allowed to choose their MCO from among those available in the areas in which they live.

The State has never used a competitive bidding process to procure MCOs, although such a process has been used to procure other managed care contractors. TennCare contracted with any qualified MCO that had a provider network by the implementation date, agreed to comply with the contract requirements, and accepted the capitation rates established by the State. TennCare MCOs originally operated under a full-risk capitation. However, in 1999 and early 2000, the TennCare program experienced several setbacks with some MCOs losing financial stability and exiting the program. In an effort to stabilize the program, by July 2002, all TennCare MCOs were operating under a Stabilization Plan. Under the Stabilization Plan MCOs were paid an

administrative fee based on an enrollee's eligibility category and were not at risk for the cost of medical services. In addition, the State developed a plan, called TennCare Select, whose risk is backed by the State. TennCare Select was created to serve as a backup if other MCOs failed or there was inadequate MCO capacity in any area of the state and to be the MCO for certain populations, including children in state custody and children eligible for SSI. TennCare Select is administered by Volunteer State Health Plan, a wholly-owned subsidiary of BlueCross BlueShield of Tennessee.

The following are key milestones in TennCare's history:

Date	Event
January 1, 1994	TennCare was implemented. Entire Medicaid population was moved into managed care and enrollment was opened to Uninsured and Uninsurable population. State contracted with 12 MCOs to deliver all services (except long-term care) via a fully capitated reimbursement arrangement.
December 31, 1994	The "Uninsured" category was closed.
July 1, 1996	TennCare Partners, a carve-out for behavioral health services, began.
April 1, 1997	Enrollment was re-opened to uninsured children under the age of 18; cost sharing was required for those with incomes above the poverty level.
May 21, 1997	Enrollment was opened to "dislocated workers"; cost sharing was required for individuals with incomes above the poverty level.
July 1998	The state carved-out behavioral health pharmaceuticals.

Date	Event
January 2000	The Grier Consent Decree was signed. The Decree significantly limited the ability of MCOs to effectively manage care.
May 2000	<p>Active recruitment was initiated to bring new MCOs into the program.</p> <p>Access MedPlus (one of the larger statewide MCOs) was placed under the administrative supervision of the Tennessee Department of Commerce and Insurance, primarily for the failed implementation of a new claims processing system.</p>
July 2000	Pharmacy benefits for dual eligibles were carved out of the MCO program.
July 2001	Two new MCOs, Better Health Plans and Universal Care, began operating in the West and Middle grand divisions, respectively.
October 2001	Contract with Access MedPlus was terminated.

Date	Event
July 1, 2002	<p>Period of “stabilization” began with capitated risk arrangement replaced by an ASO-type arrangement in which MCOs were paid an administrative fee and cost of health care services were “passed through” to the State.</p> <p>TennCare was revamped and divided into two programs: one for Medicaid eligibles (TennCare Medicaid) and one for demonstration eligibles (TennCare Standard); each program was to have its own benefit structure.</p> <p>Eligibility changes in the new program included the following:</p> <ul style="list-style-type: none"> • The category of “Uninsurables” was replaced by a category called “Medically Eligibles” and eligibility criteria were tightened • The definition of “Uninsureds” was tightened • “Reverification” was instituted whereby DHS determined whether persons in the demonstration population were eligible for Medicaid, eligible for TennCare under the new criteria, or no longer eligible for TennCare under the new criteria <p>(TennCare continues to have a reverification process for enrollees.)</p>
October 2002	A dental carve-out program was initiated.

Date	Event
June 1, 2003	Contract with Universal was terminated and Universal's enrollees moved to TennCare Select.
July 1, 2003	All pharmacy services were carved out to a single Pharmacy Benefits Manager.
August 1, 2003	The State's contract with Xantus (a larger MCO operating in middle Tennessee) was terminated and Xantus' enrollees moved to TennCare Select.
July 1, 2004	BHO procurement resulted in a full risk arrangement in the East Grand Region.
Late 2004	Budget crisis and impasse with Tennessee Justice Center regarding relief from consent decrees.
Early 2005	TennCare reform plan is finalized that includes disenrollments and benefit reductions.
July/August 2005	Disenrollment of 190,000 TennCare Standard adults begins. Pharmacy benefit limits implemented.
August 2005	State obtains substantial relief from most onerous provisions of Grier Consent Decree.

B. Litigation

Both before and after the creation of TennCare, several lawsuits were filed against the State related to its Medicaid program. These lawsuits resulted in consent decrees that in many instances imposed additional obligations for the State above and beyond what is required by federal law or by the Federal government in the TennCare demonstration project. One key case is *Grier v. Goetz*, which deals with the procedural protections to be afforded enrollees when

TennCare services are denied, reduced, delayed, suspended, or terminated. Failure of the plaintiffs to yield in this particular consent decree was the primary road block that prevented implementation to the Governor's original proposal which would have preserved full enrollment. On June 15, 2005, the State filed a motion to modify the revised consent decree (previously modified in 2003) in a number of respects that would enable effective implementation of reforms to the TennCare program, consistent with the recent waiver amendments approved by the Federal government. In a series of orders the Court granted in part and denied in part the State's motion. Among other things, the Court's ruling reduces the State's obligation to provide an interim supply of non-preferred drugs when prescribed without prior authorization; confirmed the State's ability to impose and enforce numerical limits on certain benefits; recognized the State's right to dismiss without a hearing enrollee appeals that fail to raise a valid factual dispute; and restored the State's ability to appeal from adverse decisions of administrative law judges.

C. Lessons Learned

The original vision of TennCare was simple yet elegant. The program, designed in 1993 when states were attempting to harness the market power of the Medicaid program and use its resources to extend coverage to otherwise uninsured individuals, was envisioned as a coverage initiative that would fill the gap between the Medicaid program and private coverage through employment.

Over time, the program has experienced its share of difficulties. In part because the program was implemented so quickly, the State began with some "home-grown" health plans that were inexperienced in managing care for a sicker and more vulnerable population and were undercapitalized for the task at hand.

A series of changing TennCare Directors also contributed to the sense that the program lacked strong leadership. And, as each Director brought his or her own perspective to the program, policy changes were frequent and inconsistent. These factors led to a series of lawsuits brought by an effective advocate and the litigation and consent decrees made it almost impossible to run the program in a cost-effective fashion.

However, under the leadership of Governor Bredesen and the new TennCare management team, the State has substantially brought the program under control. Through a series of Circuit Court reversals of the local federal judges, the State has sought and achieved relief on some of the most onerous provisions of its various consent decrees, eligibility and membership of the program has stabilized, the stabilization period has resulted in better cost and utilization information that the State can use to set actuarially sound rates, and the plans that continue to operate in the State are back in a risk-sharing arrangement that has resulted in more federal support for the program.

D. Recent and Proposed Changes

In the late summer of 2003, Governor Bredesen worked with a group of stakeholders to commission an independent study of the financial viability of TennCare. The study concluded that, “even with current and planned improvement efforts and solid program management, TennCare as it is constructed today will not be financially viable.” On February 17, 2004, the Governor presented his TennCare reform plan to the General Assembly. Immediately after this the Commissioner of Finance and Administration began a process called “TennCare Transformation” to develop plans for implementing the broad themes laid out by the Governor emphasizing benefit, not beneficiary, limitations. Much of this planned restructuring was blocked by the previously mentioned consent decrees negotiated by a prior administration. The state subsequently fought for and achieved broad legal victories from the problematic provisions that prevented implementation of the original plan. These proposals were formally submitted to the Federal government in September of 2004, with revisions submitted in February of 2005. As of October 2005, approved reforms have included:

- Elimination of coverage of adults in certain optional and expansion eligibility groups and the procedures for disenrollment
- Elimination of coverage of certain optional Medicaid services for adults
- New pharmacy limits for some adults
- Nominal pharmacy copayments for some TennCare enrollees

Additional changes, including non-pharmacy benefit limits (see below), are still

pending with the Federal government.

Eligibility

TennCare currently consists of traditional Medicaid coverage groups (TennCare Medicaid) and an expanded population of children (TennCare Standard).

TennCare Medicaid

In addition to the Medicaid mandatory populations (e.g., low income families and children, pregnant women and children, aged, blind and disabled at specified income levels), the eligibility categories for TennCare Medicaid include various optional groups such as uninsured women under age 65 who have been CDC certified as needing treatment for breast or cervical cancer, medically needy pregnant women, certain medically needy children under age 21, individuals who would be eligible for SSI if they were not in a medical institution, and individuals in a nursing facility/ICF-MR with incomes up to 300 percent of the SSI benefit rate.

Also, about 97,000 non-pregnant adults who were previously enrolled as medically needy have been allowed to remain on the program. The State was granted authority from the Federal government to eliminate coverage for this group and disenroll existing enrollees. Although the State did close enrollment for non-pregnant medically needy adults in April, those who were already enrolled have retained their TennCare eligibility. The administration has committed to reopening this program by July of 2006.

TennCare Standard

As a result of changes approved by the Federal government in March 2005, enrollment in TennCare Standard (except for children losing eligibility for TennCare Medicaid) was closed, and adults in TennCare Standard are being disenrolled. Thus, by the time the reformed program is implemented, TennCare Standard will only include children in one of the following eligibility categories:

- Uninsured children under age 19 with family incomes up to 200 percent of

the federal poverty level (FPL) who were enrolled in TennCare on April 29, 2005

- Uninsured children under age 19 who meet the “medically eligible” criteria (has a health condition that makes the child uninsurable) and who were enrolled in TennCare on April 29, 2005
- Children under age 19 who are no longer eligible for TennCare Medicaid and who meet either the “uninsured” or the “medically eligible” criteria stated above

Following the planned disenrollments, there will be approximately 40,000 children in TennCare Standard statewide; approximately 10,000 of these children live in the Middle Region.

Benefit Package

In June 2005, the Federal government approved various changes to the TennCare benefit packages, including changes to both non-pharmacy and pharmacy services.

Non-Pharmacy Services

The following medical and behavioral health services are covered by TennCare. Currently there are very few limits on covered services other than medical necessity. However, the State has requested authority from the Federal government to implement additional limits effective January 1, 2006. The chart below lists the current service (and limits if any) and the proposed limits. References to “non-institutionalized” means enrollees who are not receiving TennCare reimbursed long-term care services (defined as services in a nursing facility, including a nursing facility for people with mental retardation, or services through a home and community based waiver).

Service	Proposed Limits
Inpatient Hospital Services	20 days per calendar year for non-institutionalized TennCare Medicaid adults aged 21 and older
Outpatient Facility Services	8 visits per calendar year for non-institutionalized Medicaid adults aged 21 and older
Physician Inpatient Services	For adults aged 21 and older, visits are limited to those occurring during 20 days of inpatient hospitalization (all physician visits in a single day count as one visit)
Physician Outpatient/Community Health Clinic/Other Clinic Services	12 visits per calendar year for non-institutionalized adults aged 21 and older
EPSDT Services (only for Medicaid/Standard enrollees under age 21)	Only for Medicaid/Standard enrollees under age 21
Preventive Care Services	Preventive care service will be subject to the benefit limits mentioned above, depending on where they are delivered and what type of provider delivers them
Lab and X-Ray Services	10 visits per calendar year for non-institutionalized adults aged 21 and older
Hospice Care	No quantitative limits
Dental Services (only for Medicaid/Standard enrollees under age 21; provided by dental benefits manager)	Only for Medicaid/Standard enrollees under age 21; provided by dental benefits manager
Home Health Services	No quantitative limits
Vision Services	No quantitative limits
Durable Medical Equipment	No quantitative limits
Medical Supplies	No quantitative limits

Service	Proposed Limits
Emergency Air and Ground Ambulance	No quantitative limits
Non-Emergency Transportation	No quantitative limits
Renal Dialysis Services	No quantitative limits
Chiropractic Services (when determined cost-effective by the MCO)	Only for Medicaid/Standard enrollees under age 21
Reconstructive Breast Surgery	No quantitative limits
Speech, Occupational, and Physical Therapy	No quantitative limits
Organ Transplant and Donor Procurement	No quantitative limits
Psychiatric Inpatient Facility Services & 24-Hour Residential Treatment	45 days per calendar year for non-institutionalized adults aged 21 and older
Physician Psychiatric Inpatient Services	No quantitative limits
Outpatient Mental Health Services	No quantitative limits
Mental Health Crisis Services	No quantitative limits
Inpatient/Residential and Outpatient Substance Abuse Treatment Services (non-SPMI adults aged 21 and older limited to ten days detox in lifetime and \$30,000 lifetime substance abuse limit)	All adults aged 21 and older limited to \$30,000 in lifetime substance abuse benefits and ten days detox
Mental Health Case Management	No quantitative limits

Service	Proposed Limits
Out-of-State Services	Limited to (i) emergency services, (ii) non-emergency urgent care services because the enrollee's health would be endangered if required to travel subject to prior authorization by the MCO, (iii) covered services provided by out-of-state providers in network or (iv) covered services provided by out-of-network providers if services are not readily available in the network or in-state and as prior authorized by the MCO.

As Tennessee implements the proposed benefit limits, the TennCare program will identify a short-list of encounter types and products that will not count toward the benefit limits. Examples of procedures and services on the short list include renal dialysis, certain cancer therapy, global obstetric services, certain laboratory tests, and certain types of equipment and supplies

Pharmacy Benefits

In June 2005, the Federal government approved a number of changes to pharmacy coverage for TennCare enrollees. Currently, pharmacy coverage for TennCare is as follows:

- Children under age 21 (whether in TennCare Medicaid or TennCare Standard) are eligible for medically necessary pharmacy services (including OTC medications) without limits.
- Adults age 21 and older in TennCare Medicaid who are receiving TennCare-reimbursed long-term care services (nursing facility and home and community based waiver services) can receive medically necessary pharmacy services (prescription drugs, not OTC medications) without limits

- Adults age 21 and older in TennCare Medicaid who are not receiving TennCare reimbursed long-term care are only allowed five prescriptions/refills per month of which no more than two can be brand name drugs. However, there is a broad “pharmacy short list” that identifies drugs that do not count against the limits (for a current list go to <https://tennessee.fhsc.com/>).
- Over-the-counter (OTC) medications are not covered for any TennCare Medicaid adults, with the exception of prenatal vitamins prescribed for pregnant women.

Cost Sharing

Certain TennCare enrollees are responsible for premiums and copayments. TennCare Standard enrollees with family income at or above 100% of FPL are responsible for monthly premiums that range from \$20 to \$550 for individuals and \$40 to \$1,375 for families.

Pharmacy copayments apply to all TennCare Standard enrollees at or above 100% of FPL as well as TennCare Medicaid adults who are not receiving TennCare reimbursed long-term care services. The pharmacy copayment is \$3 per brand name drug. There is no copayment for generic drugs. Pharmacy copayments do not apply to family planning services, emergency services, enrollees who are pregnant, enrollees receiving hospice care, or enrollees receiving TennCare-reimbursed long-term care services (defined above). There is no out-of-pocket maximum.

Copayments for non-pharmacy services only apply to TennCare Standard enrollees with incomes at or above 100% of poverty. The copayments for these enrollees are as follows:

Poverty Level	Copayment Amounts
100% - 199%	\$25, Hospital Emergency Room (waived if admitted) \$5, Primary Care Provider and Community Mental Health Agency Services \$15, Physician Specialists (including Psychiatrists) \$100, Inpatient Hospital Admission
200% and above	\$50, Hospital Emergency Room (waived if admitted) \$10, Primary Care Provider and Community Mental Health Agency Services \$25, Physician Specialists (including Psychiatrists) \$200, Inpatient Hospital Admission

There is no out-of-pocket maximum. However, copayments do not apply to certain preventive services.

Delivery System and MCO Reimbursement

Currently Tennessee contracts with seven MCOs. Three MCOs serve only East Tennessee, one MCO serves Middle Tennessee (Davidson County only), and three MCOs serve only West Tennessee. In addition, Volunteer State Health Plan (a wholly owned subsidiary of BlueCross BlueShield of Tennessee) administers TennCare Select, which is statewide.

As noted above, the MCOs are not currently paid using a capitated full-risk arrangement. However, beginning in July of 2005 TennCare implemented a shared risk arrangement. This includes a risk and bonus component, placing 10% of the administrative fee at risk and providing a bonus potential to earn up to 15% of the administrative fee for exceeding specified performance measures. The performance measures include a medical services budget target, usage of generic drugs, completion of major milestones for NCQA accreditation, EPSDT compliance, non-emergency visits to the emergency room, and inpatient admissions.

In addition to the seven MCOs, Tennessee contracts with one pharmacy benefits manager (PBM), one dental benefits manager (DBM), and two behavioral health

organizations (BHOs).

Financial Snapshot

The operating budget for state fiscal year (SFY) 2006 is as follows:

- Total operating budget (non-payroll): \$8.234 billion
- MCO costs (administration and medical): \$2.674 billion
- Pharmacy costs: \$2.070 billion
- Nursing home costs: \$840 million
- BHO costs (administration and medical): \$415 million

IV. TennCare Middle Region -- Reformed Model

Tennessee plans to continue reforming TennCare to provide quality services while controlling costs. Tennessee intends to pilot this “reformed model” in the Middle Region. The key features of the reformed model are as follows:

- Capitation
- Improved continuity of care, including coordination of behavioral health benefits and MCO involvement with pharmacy management (pharmacy carve-out will continue)
- More aggressive and robust disease management
- Increased EPSDT incentives
- Two MCOs, each participating across the entire Middle Region
- TennCare Select as a back-up plan and the plan for children served by the Department of Children’s Services (DCS) as well as children who are SSI eligible

As part of its reform efforts, the State intends to return to a capitated managed care delivery system. This is critical to managing the TennCare program. The State also wants to contract with MCOs that can effectively coordinate services across the full continuum of care – medical/surgical, behavioral health, and long-term care services. MCOs may use integrated delivery systems to provide behavioral services or may contract with a licensed behavioral health organization; however, the MCO is expected to be the primary bidder and will be

primarily responsible. It is expected that this arrangement will improve continuity of care for enrollees as well as reducing administrative hassles for both enrollees and providers. MCOs may subcontract with a behavioral health organization (BHO) for behavioral health services, but the MCO will be primarily responsible for managing and coordinating physical and behavioral health services with oversight of the behavioral health services component from the State's Mental Health and Developmental Disabilities Department. In addition, although long-term care services (nursing facility and home and community based waiver services) will not be included in the MCO contract, MCOs will be responsible for coordinating long-term care services for enrollees. Similarly, MCOs will be responsible for coordinating services covered by Medicare for enrollees eligible for both Medicare and Medicaid. Since pharmacy has been a key driver of expenditure growth in the TennCare program, the MCOs will, in conjunction with the PBM, support efforts to manage the pharmacy benefit.

A major component of the reformed model is disease management. Disease management is a tested method for improving quality of care and health status while reducing costs. Thus, Tennessee intends to significantly expand disease management programs for TennCare enrollees. Tennessee will also continue to focus on increasing EPSDT screenings and is considering the use of incentives to reward MCOs that meet the specified adjusted periodic screening rate of 80%. The State would like to provide a choice of MCOs to TennCare enrollees and therefore intends to contract with two MCOs in the middle region of the state. Tennessee will retain TennCare Select as a back-up plan and as the plan for children involved with the Department of Children's Services (DCS) as well as children eligible for SSI.

Additional information about the reformed model is included in Section V.

V. Questions

This RFI is issued to obtain information only and is not intended to directly result in contracts with any respondent

INSTRUCTIONS

Only organizations licensed to accept risk in Tennessee or another state should respond to this RFI. Please provide clear and concise responses to the questions in Section V. **Responses shall be a maximum of 35 pages (including any attachments).**

Responses that include "Proprietary" information should be clearly marked; the State will not release proprietary information, but cannot protect information from distribution that is subject to the Freedom of Information Act.

ADDITIONAL INFORMATION

The State will have an information session for potential respondents. Details about this session (date, time, and place) will be posted on the TennCare website (www.tennessee.gov/tenncare/).

Additional information related to TennCare can also be found on the TennCare website.

DUE DATE

Responses to the questions on the following pages must be received by **10:00 a.m. Central Standard Time, Monday, December 5, 2005** to be considered by the State. Please include two hard copies and an electronic copy (MS Word) on CD or diskette. Responses should be sent to:

Alma Chilton, Contract Coordinator
Bureau of TennCare
310 Great Circle Rd
Nashville, TN 37243
(615) 507-6384
alma.chilton@state.tn.us

CORPORATE BACKGROUND AND EXPERIENCE

Please provide the information requested below about your organization.

1. Corporate Information

- Name
- Address
- Telephone Number
- Fax Number
- E-Mail Address

2. If a subsidiary or affiliate of a parent organization, corporate information of parent organization

- Name
- Address of Corporate Headquarters
- Telephone Number
- Fax Number
- E-Mail Address

3. State of incorporation or where otherwise organized to do business

4. States where currently licensed to accept risk and a description of each license

5. Contact Information

- Name
- Title
- Telephone Number
- Fax Number
- E-Mail Address

6. Program Experience - General

Given TennCare's history with small, inexperienced plans becoming insolvent, the State is interested in contracting with MCOs that have substantial experience with capitation, particularly for the Medicaid population. Tennessee also intends to require that all MCOs be NCQA-accredited or receive NCQA-accreditation for the Medicaid product within a specified time period after contract award.

a) Do you have at least three years Medicaid experience under capitation? If yes, please identify the states and contract periods. If no, do you have at least three years of experience under capitation in another market?

b) Are you currently accredited by NCQA for your Medicaid product line? If no, are your or any other plans operated by your parent or affiliate NCQA accredited? Which product lines? Would you be willing to become NCQA accredited within a reasonable period of time after contract award? Do you have experience with HEDIS and CAHPS? Please explain.

c) Do you currently contract with any State to provide Medicaid services? If yes, proceed to question 7. If no, proceed to question 10.

7. Medicaid Program Experience - Services

Using the list below, please provide a chart that indicates for each of the states where you currently contract: 1) whether you provide the service; and 2) whether you provide the service directly or through a subcontract arrangement.

- a. Physical Health Benefits
- b. Dental Benefits
- c. Vision Benefits
- d. Non-Emergency Transportation
- e. Behavioral Health Benefits
- f. Pharmacy Benefits

- g. Long-Term Care Benefits (nursing facility and home and community based waiver services)
- h. Home Health
- i. Claims Processing and Adjudication
- j. Quality Assurance
- k. Utilization Management
- l. Case Management
- m. Disease Management
- n. Provider Credentialing
- o. Enrollment Assistance
- p. Member Services (inquiry, id cards)
- q. Member Grievances/Appeals

8. Medicaid Program Experience - Population

Using the list below, please submit a chart that includes for each of the states where you currently contract: 1) the population(s) served; and 2) the approximate number of individuals served in each population.

- Aged, Blind and Disabled – excluding dual eligibles
- Dual Eligibles: individuals eligible for both Medicaid and Medicare
- TANF and TANF-Related
- SCHIP
- Waiver Expansion Population (low-income uninsured)
- SPMI (Seriously and Persistently Mentally Ill)
- SED (Seriously Emotionally Disturbed Children/Youth)

9. Medicaid Program Experience – Payment Methodology

Please submit a chart that indicates the payment methodology for each state contract, specifically addressing the risk methodology, e.g., full-risk, partial risk, shared risk, etc. Please also describe any financial incentives you currently participate in, including the applicable service(s) and the measures.

10. Experience – Former Medicaid and/or Commercial

If you currently do not contract to provide Medicaid program services, but have in the past, please provide a brief description of the services you provided and the populations you served. Please also indicate the dates of your previous Medicaid contract(s), and indicate the state you contracted with to provide Medicaid services. If you have never contracted to provide Medicaid services, please provide a brief description of the services you provide and the populations/markets you serve.

11. Reformed Managed Care Model

As part of its reform efforts, the State of Tennessee intends to return to a capitated managed care delivery system. The State is interested in contracting with experienced plans that are capable of coordinating services across the full continuum of care – from preventive and primary care services to long-term care services, as well as across physical and behavioral health conditions. The MCO benefit package will include behavioral health services, but long-term care services and pharmacy services will continue to be carved-out. As part of this emphasis on management and coordination of care the State intends to include a strengthened disease management strategy designed to manage high cost conditions and to manage care across the continuum of service.

A. Behavioral Health

Unlike the current program, the State intends to coordinate behavioral and physical health services through the MCO relationship in order to improve coordination of care. This decision results from (a) the State's previous experience with disputes between the MCO and BHO regarding the responsibilities of each entity for particular patients or diagnoses and (b) the high proportion of behavioral health products and services provided by general and family practitioners and pediatricians, currently beyond the reach of the BHO's expertise. The State also seeks to expand its options relative to the likely bidding pool in order to ensure participation of the broadest array of experienced candidates. Thus, both single-entity, "pure-

play” BHOs and MCOs, as well as integrated health plans may participate; however, the MCO would be expected to be the primary contractor and to fully manage and coordinate an enrollee’s physical health and behavioral health conditions.

1. Is your organization currently responsible for providing behavioral health services? If yes, in what state Medicaid programs? Please describe the services you provide and to what populations. Please specify if you serve individuals with serious emotional disturbance (SED) and/or individuals with severe persistent mental illness (SPMI). Please also specify whether you provide these services directly or whether you use a subcontract arrangement. If a subcontract arrangement is used, please fully describe such arrangements and how coordination across entities is ensured. How/who handles member/provider services, appeals, claims, etc. How is the subcontractor paid?

2. Please describe your medical management model for care coordination and service integration between behavioral health providers and physical health providers, in particular an individual’s primary care provider. Please describe your experience with ethnically and racially diverse populations in physical health and behavioral health settings.

3. While the state believes that the proposed coordinated approach will improve continuity of care broadly, TennCare is particularly concerned with maintaining the highest quality of care for those individuals on our program with SED and SPMI.

- a. Please describe your experience with these populations, including specific programs and interventions (e.g., early intervention, psychiatric rehabilitation and recovery).
- b. What structural or contractual design choices would you recommend to ensure the needs of these populations are met?
- c. Would your interest level in bidding be positively or negatively impacted if the state were to consider excluding these individuals from this proposal?
- d. Would your response to (c) change if the state were to adopt an alternative, more limited or no-risk arrangement for this

population?

4. Please describe your experience working with essential community providers such as community health clinics and community mental health agencies.
5. Based on your experience coordinating physical and behavioral health services, do you have any specific recommendations regarding the design of the behavioral health proposal for TennCare? More specifically, what financial guarantees, if any, might be necessary to ensure appropriate funding for these critical services?

B. Pharmacy Services

Pharmacy has been a key driver of expenditure growth in the TennCare program. In an effort to control pharmacy costs, the State carved-out pharmacy and contracted with a pharmacy benefits manager (PBM). The State intends to continue the current PBM contract and the carve-out of pharmacy services. The MCO, in conjunction with the PBM, will support all efforts to manage the pharmacy benefit, including, but not limited to, provider education; identification and monitoring of outlier prescribers and users; and coordination of prescriptions across providers.

1. Please describe your approach to a pharmacy carve-out, including specific information on your approach to pharmacy management and cost containment strategies.
2. In a pharmacy carve-out scenario, what “real-time” information would you need to manage the benefit? Please be specific.

C. Long-Term Care Services

Long-term care services (nursing facility and services through home and community based waivers) will be carved-out of the MCO benefit package. However, individuals receiving long-term care services (including the aged, blind and disabled population) will be enrolled in MCOs for their

acute and behavioral health services.

1. Please describe your methods and procedures for coordinating acute and long-term care services to reduce gaps in services and prevent duplication of services.
2. What incentives would you recommend including in the MCO contract to drive home and community-based services as a viable alternative to institutional care?

D. EPSDT Incentives

As part of the TennCare Middle Region reform the State is focusing efforts on enhanced EPSDT screening rates and compliance with the periodicity schedule. The State is considering the use of incentives to reward MCOs that achieve specific targets.

1. Please describe your current approach to EPSDT services, including your outreach and education component. In addition, if you currently use physician incentive programs to increase participation in EPSDT please describe these initiatives. Also, please provide us with your recommendations regarding the proposed incentives for MCOs, including appropriate and measurable targets, and meaningful incentives.

E. Utilization Management/Medical Management (UM/MM)

Essential to controlling the current rate of TennCare expenditure growth is a comprehensive and successful utilization and medical management program. As described above, Tennessee intends to have service limits for various benefits, and the MCO will be responsible for managing care within those limits. The proposal currently before the Federal government would allow the State to implement “hard” benefit limits. The only exceptions would include services on the “short list”, which would not count toward benefit limits and continue to be available to enrollees after benefit limits are hit. However, the State is considering moving toward “soft” benefit limits in the future, where services beyond the benefit limit

could be provided as cost-effective alternatives to covered services. The MCO would have the lead role in deciding whether to provide services over the applicable benefit limits. The State expects that these services would be authorized using a prior authorization process.

1. Please describe any experience you have managing care in a state with benefit limits, including both “hard” and “soft” limits. In particular, please describe any experience you have had implementing prior authorization processes as a mechanism to authorize services in excess of benefit limits. Please describe the prior authorization process you would employ for “soft” limits and the general criteria that would be utilized to evaluate requests.

2. Based on your experience, please provide any recommendations regarding specific UM/MM requirements for the State to consider, particularly the use of “soft” limits.

F. Disease Management

Physical Health

The State intends to incorporate the principles of disease management into its reformed managed care program and a comprehensive and coordinated approach will be expected of all participating MCOs. At a minimum the expectation would be that the MCO apply disease management techniques to the following physical health conditions:

- Diabetes mellitus
- Congestive heart failure
- Coronary artery disease
- Asthma
- Chronic-obstructive pulmonary disease
- High-risk obstetrics

1. Do you have a formal disease management program? If yes, where is it currently being used, e.g., which State Medicaid programs?

Again, if yes, on which conditions does your program focus today?

2. Is the function fully performed within your organization or do you subcontract with another entity? If a subcontract arrangement is used, please fully describe such arrangements and how coordination across entities is ensured.

3. Please describe your disease management approach, and address each of the above conditions specifically. Include in your description how you identify individuals in need of disease management interventions more broadly (including potential future high-cost utilizers); your outreach and education approach; the number of individuals served; your approach to physician behavior, including the use of clinical guidelines; staff qualifications; your experience and approach to managing within the context of benefit limits; and a description of measurable outcomes resulting from the disease management intervention. Please also describe what additional health conditions you might recommended for targeted intervention techniques (e.g., obesity, pain management)?

Behavioral Health

In addition, the following behavioral health conditions are targeted for care management interventions:

- Schizophrenia
- Bipolar disorder
- Major depression
- Co-occurring mental illness/substance abuse

4. Does your care management program include behavioral health conditions? If yes, where is it currently being used?

5. Is the function for behavioral health care management fully performed within your organization or do you subcontract with another entity? If a subcontract arrangement is used, please fully describe such arrangements and how coordination across entities is ensured.

6. Please describe your care management approach to behavioral health conditions, addressing each of the above conditions specifically. Include in your description how you identify individuals in need of disease management interventions; your outreach and education approach; approach to co-morbid mental and physical conditions; the number of individuals served; your approach to provider behavior, including the use of clinical guidelines; staff qualifications; your experience and approach to managing within benefit limits; and a description of measurable outcomes resulting from the management intervention.

G. Capitation Model

Under the TennCare reformed managed care model the State will be returning to capitated managed care.

1. Please describe your experience operating under a risk contract for Medicaid and any concerns or recommendations associated with this approach.
2. Please indicate if a full-risk capitation environment would negatively or positively affect your decision to participate.
3. The State is committed to a capitated approach for the core benefit package, as described above, for all enrollees. If you prefer an arrangement other than full risk, however, please describe the mechanisms you would prefer, such as:
 - a. State supported stop loss provisions based on annual per member expenditures (e.g., the state reimburses X% of costs between \$X and \$X per member per year)
 - b. If the State adopted “soft” benefit limits, State supported stop loss provisions based on per member benefit utilization (e.g., the state reimburses X% of hospital visits over the 20 day annual limit)
 - c. If the State adopted “soft” benefit limits, aggregate risk sharing

(e.g., the state reimburses X% of costs in excess of X% of capitation payments)

d. Other

4. Does your participation depend upon a minimum number of covered lives? If yes, what is the minimum number?

H. Data and Systems Capability

Critical to the success of the program is the availability of robust, timely data, including encounter data, for use by the State and MCOs to manage and monitor the program. The State is very interested in MCO capacity to obtain and provide data and reports to the State, and capacity to use data for ongoing program monitoring and quality assurance.

1. Please list and describe data, including encounter data, and reports you have experience producing for external monitoring. Please list those states for whom you provide this information.

2. Please describe how and what data you use to monitor, measure, and evaluate your performance, including the performance of your network providers and any subcontractors. Please be as specific as possible.

I. Net Worth and Restricted Deposit Requirements

In addition to the statutory net worth and restricted deposit requirements for HMOs, TennCare MCOs must comply with contractual net worth and restricted deposit requirements. The statutory net worth requirement is made on an annual basis based on historical data (see TCA, Section 56-32-212). The MCO contract requires that the minimum statutory net worth requirement be recalculated before a significant enrollment expansion occurs. In terms of reserves, statutorily MCOs must maintain a restricted deposit in the amount of \$900,000 plus specified amounts of premium revenue in excess of \$20 million (see TCA, Section 56-32-212). The MCO contract requires MCOs to maintain a restricted deposit equal to the statutory net worth requirement. This requirement will be revised to clarify that the increased restricted deposit amount shall be calculated based on the MCO's TennCare revenue, unless that amount is less than the restricted deposit required by statute. If the amount calculated using only TennCare revenue is less than the restricted deposit amount required by statute, then the contractually required amount shall be equal to the restricted deposit required by statute.

1. Do you consider the net worth and depositing requirements to be a deterrent to contracting with TennCare? If so, please explain.

J. Implementation Timeframe

The State's anticipated timeframe for the procurement and implementation of the TennCare Middle Region reform calls for bid procurement in January, with selection of MCOs in April and service delivery beginning in October. MCOs and any subcontractors accepting risk (e.g., BHOs) will have to be appropriately licensed in Tennessee prior to implementation.

1. Does the anticipated timeframe of an April 2006 contract award and an October 2006 implementation date impact your decision whether to participate in the program? If yes, how?

2. Do you have suggestions or recommendations regarding the procurement and implementation timeframe? What is your recommended minimal and optimal timeframe between contract award and implementation?